Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS RADIOLOGY GROUP
P O BOX 29407
SAN ANTONIO, TX 78229

Respondent Name

MITSUI SUMITOMO INSURANCE USA

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-4139-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We originally filed bills to Reyes Automotive for services performed on the patient. We became aware that we submitted bills to the wrong place on 11/19/2010 and subsequently billed the correct insurance within 95 days."

Amount in Dispute: $145.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider failed to submit any credible proof that it submitted its original complete medical bill to the carrier by November 14, 2010. Instead, the provider submitted proof in the carrier's first EOB that the carrier received the original complete medical bill on February 25, 2011."

Response Submitted by: Flahive, Ogden & Latson, P.O. Box 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 11, 2010	CPT codes 72125 & 70450	$145.75	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.

4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 2, 2011
   - 29- Time limit for filing claim/bill has expired
   - RM2- Time limit for filing claim has expired

   Explanation of benefits dated July 1, 2011
   - 193-Original payment decision maintained.
   - 29-Time limit for filing claim/bill has expired
   - RM2- Time limit for filing claim has expired

Issues

1. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.20?
2. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code, Section §408.027 and 28 Texas Administrative Code §102.4?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.20(b) states in pertinent part "Except as provided in Texas Labor Code §408.0272…a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." Requestor states that they originally sent bill to Reyes Automotive on August 25, 2010, however, Reyes Automotive does not meet the criteria of one of the entities as described in Texas Labor Code §408.0272. Therefore, Texas Labor Code §408.0272 does not apply to the service in dispute, for that reason, the requestor in this dispute was required to send the medical bill no later than 95 days after the service in dispute was provided. 28 Texas Administrative Code §102.4(h) states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."
2. Review of the documentation submitted by the Requestor finds three copies of a medical bill with printed date 10/21/2010, 07/11/2011 and 07/12/11 in box 31 and a copy of Explanation of Benefits dated March 2, 2011 and July 1, 2011. No documentation was found to sufficiently support that a medical bill was submitted to the correct insurance carrier within 95 days from the date services were provided.
3. In accordance with Texas Labor Code §408.027, the Requestor has forfeited the right to reimbursement due to untimely submission of the medical bill for the service in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	01/13/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.